

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 18, 2001
10:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:

Payment for outpatient pain management procedures

Penny Mohr, Senior Research Director,
The Project HOPE Center for Health Affairs
Nancy Ray, Kevin Hayes

AFTERNOON SESSION

[1:38 p.m.]

MR. HACKBARTH: Could our guests in the back of the room please have a seat?

MS. RAY: Good afternoon. We're here to talk about, for the next 30 minutes, payment for outpatient interventional pain management procedures. This study is in response to a Congressional mandate and is due to the Congress by December 22nd.

At issue is does Medicare's coverage and payment policies affect beneficiaries' access to outpatient interventional pain procedures that are performed in physician's offices, hospital outpatient departments and ambulatory surgery centers.

To assist us in examining this issue, we asked Project HOPE to look at these issues for us. Penny Mohr, who is a senior research director headed up the work. A draft report of their findings was included in your mailing materials for your review. She's here right now to present some of the major findings of her piece of effort.

MS. MOHR: Good afternoon. I'm presenting the findings from Project HOPE's study of access barriers to interventional pain management procedures among Medicare beneficiaries.

As Nancy mentioned, the purpose of this study was to investigate whether Medicare payment and coverage policies for interventional pain procedures posed access barriers to beneficiaries. Of specific concern are the wide variations in payment rates and policies among different settings of ambulatory care, such as physician's offices, hospital outpatient departments, and ambulatory surgical centers.

To complete the study, we conducted a review of the literature, reviewed Medicare policies and procedures, and conducted interviews with more than 40 experts in pain management and Medicare policies.

Pain management spans a broad array of treatments, ranging from pharmacologic to surgical interventions. This study focuses exclusively on interventional pain management procedures. These are minimally invasive procedures, such as injection of drugs in targeted areas, or ablation of targeted nerves, and some surgical techniques such as the implantation of infusion pumps or spinal cord stimulators. They include such procedures as you may be familiar with as facet joint blocks, trigger point injections, and epidural administration of morphine or steroids.

Many practitioners believe that interventional pain procedures are useful, both in the diagnosis and treatment of chronic, localized pain that does not respond well to other treatments.

Our discussions with pain management providers revealed a wide array of concerns about Medicare payment and coverage

policies. Explicit in the legislation is the concern that Medicare's basis for establishing payment rates is not consistent across different settings of ambulatory care, perhaps introducing incentives to shift care among settings for economic, rather than clinical reasons.

Also, there is a concern that for some procedures in some settings payment rates may be inadequate. There are two underlying concerns that deserve mention here. First, some providers are concerned that office-based pain management providers are often grouped with facility-based physicians such as anesthesiologists when determining practice expense allocations, resulting in a relatively low practice expense allocations.

Some providers have suggested this is because Medicare has not recognized pain management as a specialty, even though it is a board certified subspecialty of the American Medical Association.

Second, there is a concern that under the new outpatient prospective payment system for hospital outpatient departments some interventional pain procedures were placed in inappropriate payment groups because there was a lack of cost data for these procedures. Many of these procedures are performed with fluoroscopic guidance, resulting in a multiple procedure bill. And as many of you may be aware, you've dealt with this issue in the past, that multiple procedure bills were not used for allocating procedures to ambulatory payment classification groups.

In addition to concerns about variation in payment rates across ambulatory settings, there's also concern about local variation in coverage policies among Medicare contractors.

And finally, there are some quality concerns. Without exception, all clinical experts that I spoke with stated that interventional procedures may have risk, although complications are rare. For example, inappropriate needle placement could result in paralysis or death. They raised a common concern that some of the physicians providing these in their offices did not have appropriate surgical suite-like conditions and that some lack imaging equipment such as fluoroscopy which may be helpful to guide needle placement.

In our review we found there's no hard evidence that there are access problems, although there are many anecdotal reports of closures of pain management clinics. MedPAC's staff analyzed spending on interventional pain procedures in comparison with spending on physician services in general between the years of 1994 and 1999. With few exceptions, spending on these services has kept pace with that of physician services in general. That table was included in your report and is not presented here.

However, our ability to examine whether there were issues related to beneficiary access to these procedures was hampered by lack of data. For example, there's no central registry of pain management clinics, unlike dialysis facilities or ambulatory surgical centers. Pain management can take place in a variety of different settings.

Also, the lack of a pain management specialty code means we

cannot confirm the procedures we identified in the claims data were explicitly used for pain management and were not adjuncts to surgical procedures. Thus, our analysis of these data may mask access problems.

Also, many people we spoke to suggest the problem has been exacerbated in recent years and the most currently available data we have are from 1999. Therefore, although we cannot conclude there are access problems, neither can we confirm there are no problems with beneficiary access to these procedures. We need to know more.

We did find that there is some cause for concern about the manner in which Medicare pays for and determines coverage for these procedures. Many of these concerns are related to more universal issues that the Commission has dealt with in the past. For example, payment rates do vary widely across ambulatory settings, as shown in the slide. Here we present just three examples. Comparisons for all other procedures are in your report.

In the slide here we see that payments for some interventional procedures in an ambulatory surgical center are nearly twice as high as they are in an HOPD. Also, the practice expense payment is generally lower, despite the fact that physicians must maintain operating room types of precautions to safely perform these procedures in a physician's office.

There are also many legitimate concerns related to payment and coverage of these procedures in ASCs, and I would like to spend a little bit of time going over these. First, there are a large number of interventional procedures that are not on the ASC approved list. Only 46 of the 85 interventional pain procedures we identified were on the ASC approved list. This is partly due to the administrative delays in updating the approved procedure list, and partly due to the way in which CMS determines which procedures should be on the approved list.

The approved procedure list has not been updated since 1998, despite rapid technological advancement in medicine. CMS determines approved and excluded procedures for ASCs according to the percent volume in which these are done at specific sites -- like physician's offices versus ASCs versus inpatient -- analyzing Medicare claims data. Specific to interventional pain procedures, CMS determined a growing number of interventional pain procedures were being provided in physician's offices and thus determined that they could safely be performed in that setting and should not be on the ASC approved list.

Providers counter that many of the procedures excluded from the ASC approved list do require operating room type precautions. Also, there have been delays in conducting cost surveys to update payment rates. The ASC cost survey has not been fielded since 1994, despite statutory requirement that it must be performed every five years.

The fact that ASCs are paid on the basis of eight payment groups rather than the more extensive categories using HOPDs or physician's offices means that CMS is paying the same price for procedures with potentially widely varying costs.

Finally, there are wide discrepancies in what ASCs receive

for the same procedure because of varying interpretations of regulations. ASCs are required to provide only those procedures that are directly and integrally related to the performance of outpatient surgery. Consequently, payment for some adjunct procedures like fluoroscopy or durable medical equipment are supposedly bundled into the payment rate. But CMS also says that ASCs may wear many hats.

For example, if an ASC becomes a licensed supplier of durable medical equipment or a licensed independent diagnostic testing facility, they may bill separately for these items. This statement is in direct conflict with 1999 safe harbor regulations which state that all ancillary services in an ASC must be an integral part of the procedure and cannot be billed for separately.

The bottom line is that some ASCs are receiving nearly \$7,000 for the implantation of an ambulatory pain pump, while receive only \$433.

We also found problems with inconsistent coverage policies among Medicare contractors. Most coverage decisions are made by private insurance companies Medicare contracts with to process claims. Because of the large numbers of entities involved in making coverage decisions, inconsistencies in policies are common.

Not only do policies vary across localities, but a single hospital can face conflicted policies because a carrier determines policies for an ASC while a fiscal intermediary determines policies for the HOPD. However, a hospital may own both an ASC and an HOPD.

To illustrate some of these differences we examined local coverage policies for paravertebral facet joint blocks. We found that many carriers have imposed limits on the number of these procedures that can be performed in a given day. These limits vary from only two facet joint blocks on the same day to no limits.

We must say here that there is no good evidence what the appropriate number of these blocks should be, and I'm going to discuss that in a little bit.

We also found wide variations in diagnoses covered for this particular procedure, and also there were variations in the requirements for the use of fluoroscopy. Some Medicare contractors specifically state that they will not pay for this procedure unless it's performed in conjunction with fluoroscopic guidance, and others make no statement on the issue.

When we think about policy options, we find that CMS is addressing many of the issues that were raised by providers. For example, CMS granted a Medicare-recognized specialty designation for pain management last month which will take effect in January of this year. Also, a proposed rule for hospital outpatient PPS, issued in August of this year, creates several new APCs for interventional pain procedures and mitigates many of the concerns providers had raised regarding payment in that setting.

CMS is also continuing to improve the openness and evidentiary basis of its coverage determinations used both nationally and by its contractors. For some of the issues that

are not being addressed, we raise some policy options to consider. One of the common themes we revealed in the study was that the quality of scientific evidence available on interventional pain procedures is lacking. This is not uncommon for medical science in general but it is very true in interventional pain procedures.

For example, in a recent meta-analysis completed on injection therapy for subacute and chronic low back pain conducted by the Cochran collaboration they concluded these procedures are not yet shown to be effective, nor have they shown to be ineffective. We need to know more.

CMS has established precedents in jointly sponsoring clinical trials with the National Institutes of Health and pain management may be a ripe area for further joint sponsorship of these types of trials.

Medicare has also established precedents in the use of provision coverage where investigational procedures may be covered if beneficiaries receive treatments at facilities that are following a rigorous study protocol to evaluate the outcomes of care. One of the clinicians we interviewed for this study recommended that provisional coverage would be an excellent vehicle for gathering better data on many of these procedures, particularly in examining how many of them should be covered in a given day or over a period of an episode of treatment.

For example, Medicare contractors could continue to retain their restrictive limits on the number of facet joint blocks that are done in a given day but would pay for more as long as they were done in the context of a rigorous controlled study, so that data can be gathered to better guide Medicare policies in this area.

Although not explicitly a recommendation for a change in federal policies, specialty associations could also help CMS set better policies in this area with the development of cost specialty guidelines. Although there are many guidelines in the area of pain management, they are not always consistent. Cost specialty guidelines could help CMS and its contractors better understand such issues, for example as to whether fluoroscopic guidance is necessary for a particular procedure. They may also help establish minimum quality standards for the performance of these procedures in physician's offices.

Finally, there are many improvements that can be made in Medicare payment and coverage policies in ASCs. Some of the changes made in the proposed 1998 rule are suitable policy options for addressing ASC issues that we've raised. For example, inconsistencies between ASC and HOPD payment could be diminished by converting ASC procedure classifications into a more extensive grouping based on clinical aspects in addition to costs.

Also, if CMS moved toward discontinuing site of service requirements as a primary criterion for approved list it could help allay some of the concerns.

CMS should also implement a more expeditious timeline for updating costs and devising an approved procedure list.

And finally, there needs to be a movement to resolve the

conflict between the safe harbor provisions and policies for billing for DME and adjunct imaging in an ASC.

Thank you very much.

MS. RAY: Based on the findings from the Project HOPE study and staff's review of the evidence we propose one recommendation for the Commission to consider. This recommendation addresses the need for research on the use of outpatient interventional pain procedures among Medicare beneficiaries. Additional research in this area should help both CMS and its carriers in setting payment and coverage policies and it should also help providers in ensuring that they are delivering high quality care to beneficiaries.

We'd like your input on the draft report submitted by Project HOPE, our conclusions, and the draft recommendation.

DR. NEWHOUSE: Can you say a little bit about why there's not more in the way of draft recommendations, given all the material in the report about payment system?

MS. RAY: Right. Well, I think the issue is why we didn't present a draft recommendation specific to the ASC payment policies.

DR. NEWHOUSE: And the updating of the procedures and so forth and so on. There's a whole litany here.

MS. RAY: Right. Again, these problems have been raised in the context of interventional pain management procedures. We thought that there are clearly issues here but they need to be more broadly looked at from a higher level perspective, not just interventional pain procedures.

DR. NEWHOUSE: I certainly agree with that, but I don't know that there's any reason we can't say something about these in this context and note that they go well beyond pain management. Issues like provisional coverage go well beyond that.

MS. RAY: Yes, and we certainly were planning on doing that. We just didn't want to make it into a -- staff didn't propose it as a recommendation because of the fact that this is a narrow report.

DR. NEWHOUSE: I'm not sure I'm comforted by that. I think we should have a recommendation, but if we don't I think it's incumbent on us to say why we don't, given all that's here.

DR. REISCHAUER: Just on Joe's point, I would agree with you completely. I think there seems to be enough smoke here to talk about the fire in rather explicit ways.

I was interested in how you went about trying to answer, is there enough of this pain management going on? One of the metrics you used was, the spending that we do for this has grown about what spending for other physician services have been. That, of course, presumes several things. One is that it was right the first time, and secondly, that the rate of growth of these two things is about on target.

I was thinking of other ways we might address that problem. One would be looking at the literature on what's the optimal amount, and you say there's nothing -- it's confused.

The second thing would be to go to a different set of patients who are under, let's say an employer-sponsored plan who have the same kind of condition, cancer or whatever it is, and

different payment procedures that are viewed as more appropriate, and see what their utilization is versus Medicare's.

A third would be to look at the experience in some other countries and see the extent to which we rely on these types of interventions versus the Swedes or whoever is at the cutting edge of this.

Even if we did then find that we don't have enough interventional pain management going on for "optimal care" the question would be, why? One possibility, of course, is the one you examined, the Medicare payment system. But another is reluctance on the part of physicians or lack of knowledge on the part of physicians to pursue this avenue. And a third is patient preferences.

How we would disentangle all of that, if we could -- I don't think we can --

MS. MOHR: Can I just make one comment there? I've long been interested in the issues of international comparisons of the use of medical technology. I think that the problem is that when you look at that you can see variations and you can't say, is it too high or too low? It's very difficult to know what's appropriate. I think that's the question that's not answered right now.

We can make some comparisons across different groups but it's very difficult to know what's appropriate because we don't have enough evidence there.

DR. ROWE: I think one of the additional considerations that makes the utilization comparisons less reliable is that this is really an emerging technology in many clinical areas around the country. There are areas in which this is widely accepted by practicing physicians, and they refer patients for this kind of procedure, and there is a center of excellence in the area and utilization might be quite high. Then I think there are whole areas of the country where there's very little utilization of this because there just haven't been people trained in it, or the practice in the community has not yet adopted the utilization of these procedures.

So we're in that early phase of heterogeneity of some early adopters, et cetera. That would complicate some of the comparisons because the early adopters may be over-utilizing. That might not be the right -- and the late adopters may be under-utilizing. It would be hard to know what the right number I think.

MS. MOHR: My understanding is that these procedures have been around for a long time.

DR. ROWE: I agree with that.

MS. MOHR: But you're right, their use has been increasing in recent years.

MS. BURKE: I wanted to just go back for a moment to Joe's point, which I agree with entirely. But to query just a little bit, is there any aspect of the policy options that were proposed in the study with which you disagree? I mean, your decision not to be more fullsome in terms of a specific recommendation, I wondered whether there was any aspect of this with which we had substantive disagreement? Whether your decision not to go

further in terms of detail was based on a fundamental disagreement or just your thought that it wasn't what you were charged to do? I'm just trying to understand why we limited ourselves to a relatively brief reference to the need for a study on effectiveness.

MS. RAY: No, I don't in general disagree with any of the findings from the Project HOPE report or the conclusions or the policy options. I think that there may be additional payment issues out there with respect to ASCs. That if we're going to start making recommendations about ASC payment policies we should do it by looking completely at the ASC payment system, and there may be issues here that we're not taking on here. That was my mind-set in just going with this one recommendation. But having in our letter that will accompany this report to the Congress stating there our concerns about ASC payment policies and reiterate the findings from Penny's study.

MS. BURKE: I guess my only cautionary note is as I understood the intention of the study it wasn't specific to ASCs. It was specific to the issue of interventional pain management.

MS. RAY: That's correct, right. The other potential, I thought, recommendation that could also be made was the one about the different payment policies across HODs, physician offices, and hospital outpatient departments. Now MedPAC has already made a recommendation about that, and that was in our March 1999 report. Again, what I was planning on doing the next time around for this is to reference that and reiterate that.

Now if the Commission feels very strongly about that and would like to make that again as a formal recommendation then I can come back and provide that.

DR. ROSS: Before you promise the store here, I think Nancy's main point there is exactly on point, which is if we want to talk about payment consistency and other kinds of issues we should do that in a large, and not build up from particular sets of procedures.

I was just jotting down three issues, all of which amount to, go slowly here before looking for doing too many recommendations. One is, there's a basic issue of, does this work or not, that precludes fine-tuning payment policies for specific codes and specific settings.

There's a second issue relating to how far the Commission wants to go digging into coverage issues generally. That's just a resource constraint problem, given the depth of -- how far do you want to go given all the many other commitments that we have? You collectively need to make a decision about that, but my view would be caution.

But I think first things first on this one. There's an efficacy and appropriateness issue. To the extent there's payment system issues we should address them in the larger OPD-ASC-physician office issue.

MR. DEBUSK: Are we talking about efficacy or a degree of efficacy?

DR. ROSS: Degree of.

MR. DEBUSK: We know it works in a lot of cases, and there's a reason for it being there.

DR. ROSS: When I say efficacy, I mean in the sense that, as Penny said, you can't tell if there's an access problem out there. We have no evidence that there is or there is not. How far do you want to go on the basis of that finding, then to start fine-tuning the fee schedule, given that piece of evidence? That's what should be established first.

DR. LOOP: I think this is a very comprehensive report. I really enjoyed it. I think that there's probably three areas of recommendation that you could make though. One is the effectiveness of the procedures. But we're beyond whether it's effective. It's certain types of procedures, are they efficacious? For example, do implantable pumps reduce future interventions and decrease the cost? That's the kind of research that ought to be done.

But the other two recommendations are, one is, fix the inequities, fix the variations in payment, and the third is safety. Because there's a lot of perverse incentives for people to move these procedures into their offices where there's very poor guidelines, there's the wrong kind of people doing these procedures. I think safety should be somewhere in our milieu of recommendations. So I agree that we should expand the recommendations.

DR. NEWHOUSE: Murray, I don't disagree with you very often, but I disagree with you on this one. First of all, I don't think we're going to fine-tune the system. I think we're going to recommend some attention to the system.

Second, saying it's going to be done in the context of the entire system might take -- the point, that may be the best. But here I think the best is the enemy of the good, because I don't think it's going to happen for a while. This seems sufficiently high priority to me to go ahead and start in on it.

MR. HACKBARTH: Any other comments? From a process standpoint, Murray, do you have a recommendation on how we proceed here? Were you hoping to get this resolved today or is this something --

DR. ROSS: I'm always hoping for early rather than later resolution. We hear you. We'll craft some recommendations and supporting language and bring it back to you in November.

MR. HACKBARTH: Maybe this is strictly academic. Maybe it shouldn't be cast necessarily as a recommendation. Sometimes in these reports don't we just make observations about what we find? I think we could make observations that there is missing evidence about effectiveness. That we do see these disparities among payments that could be problematic. It seems like there's a lot of unanswered stuff here. We can point in the general direction.

I generally don't like this sort of recommendation. The Secretary should pursue additional research doesn't say a whole lot to me. I'd rather maybe make some statements of finding. This is what we find. These are the questions that it raises in our mind, but given the lack of information or the developing nature of this field it's difficult to be definitive.

DR. ROSS: Could I give a counter-example? You could phrase as a finding or a recommendation something to the effect of, we observe substantial disparity in the payment rates for these

services. The Secretary should investigate this. Of course, the Secretary is in fact also the person who set those payment rates and presumably did it on some basis in the first place.

You get a little bit circular here. If you want to point to some issues and say that the Commission is concerned about these -- I don't know how specific we can get on that.

MR. DEBUSK: Why don't we think about this for about 30 days and come back and revisit this? Because I think there's more here than we --

DR. LOOP: One thing you could put in the report which might get the Secretary's attention is the growth of these procedures, because it's rising as fast as any subspecialty procedures in the U.S. By the way, I don't think any international comparisons are worth doing because I think we're way ahead of most other countries, don't you?

MS. MOHR: I would say so.

DR. NELSON: I'm unclear in my mind about what kind of help Congress was seeking from us when they punted this to us. So Glenn and Murray, when you come back to us, frame the question that Congress wanted us to help answer. Somebody went to them with some case to make for some inequity or some failure to pay what was, in their mind, appropriate, and Congress punts it to us. I think we at least ought to try and get close to answering whatever question was being posed.

MR. HACKBARTH: Okay. Thank you, Penny.

MS. RAY: Okay, so now the next policy question before us. Do cancer hospitals face special circumstances that make the outpatient prospective payment system inappropriate for them, and should cancer hospitals continue to receive hold harmless payments that serve to protect these facilities from losses under the outpatient prospective payment system? This work responds to a congressional mandate that MedPAC look at the applicability of the outpatient prospective payment system for cancer hospitals. The report to the Congress is due around December 1st.

The Commission has already looked at a similar issue in our June 2001 report when we looked at the appropriateness of the outpatient prospective payment system for small rural hospitals. In our report we concluded that rural hospitals are more vulnerable to the financial risks inherent in the outpatient prospective payment system and may have fewer resources available to manage those risks. The Commission recommended that the existing hold-harmless policy for these small rural hospitals be continued until better information becomes available. Our study on the small rural hospitals was also in response to a congressional mandate.

Just a brief review of how the current payment policy works. Cancer hospitals, they are the only class of hospitals -- cancer hospitals and children's hospitals, but we're focusing today on cancer -- are the only class of hospitals for which financial protection from the effect of the outpatient prospective payment system is permanent. The BBRA protected small rural hospitals with 100 or fewer beds from financial losses but only through calendar year 2003.

Rural hospitals with more than 100 beds and virtually all

other hospitals receive transitional payments through 2003 if they are paid less under the prospective payment system than they would have been paid under the pre-PPS rules. However, unlike the cancer hospitals, they do not recoup the full difference and the extent of additional payment declines between now and 2003.

To summarize our findings, staff found evidence showing that cancer hospitals do have a narrower service mix, higher unit costs, and poorer financial performance under Medicare. However, we were unable to analyze claims data from the post outpatient PPS period to examine the extent to which cancer hospitals receive hold-harmless payments. CMS has not made those data available yet because of validity concerns.

So what did we find specifically? One of the reasons we might think that cancer hospitals are more vulnerable to the financial risks of prospective payment is that a larger share of their outpatient revenues is from Medicare than other hospitals. This increases their exposure to the financial risks inherent in prospective payment. This does appear to be the case. Cancer hospitals outpatient share within Medicare is 32 percent compared with 14 percent overall.

In your mailing materials there was a table showing differences in the types of services cancer hospitals provide on an outpatient basis than other hospitals. The impact of these differences in service mix on the financial viability of cancer hospitals under PPS depends on the adequacy of payments for each type of service. Again, we don't have hard evidence to date. At issue is whether the outpatient prospective payment system is appropriately paying for the mix of services provided by cancer hospitals.

There is some concern that in the method CMS used in developing the outpatient prospective payment system that it may not appropriately pay for these services. For example, the use of the median values resulted in lower payments than mean values when CMS was developing the relative weights. This may affect cancer hospitals disproportionately compared with other hospitals, as I'll show you on the next slide, because they do incur higher costs on average than do other hospitals.

Again to repeat a finding that we just talked about under the pain management study, CMS excluded multiple procedure claims to reduce the risk of improperly assigning cost to the wrong service. Excluding multiple procedure claims could skew the calculation of APC weights if hospitals with higher costs are more likely to submit these claims. Some preliminary evidence does suggest that this is the case.

CMS reported that cancer hospitals' unit costs are about 20 percent greater than other hospitals. CMS solely attributed this finding to the under-coding of services in the pre-outpatient claims data.

We offer several other reasons for your consideration why these hospitals may incur higher unit costs. One of them being that they appear to be treating patients of higher acuity on average than other hospitals. Secondly, that they do provide enhanced patient care. What I mean by that is their role as a national cancer institute, coordinator center, their involvement

in clinical trials, their use of cancer protocols using state-of-the-art treatments as well as providing free services related to cancer screening.

Cancer hospitals cannot offset their outpatient losses with inpatient revenues. Cancer hospitals don't have the same ability because they are not paid under the acute care prospective payment system for inpatient services. Rather, they are paid under TEFRA. Under TEFRA, cancer hospital payments for inpatient operating costs are based on each facility's Medicare-allowable inpatient operating costs, subject to a limit based on a target and Medicare operating cost per discharge.

So we have presented some tables for you in your mailing materials on the Medicare inpatient-outpatient and Medicare total margin. Before the introduction of the outpatient prospective payment system, cancer hospitals had lower Medicare outpatient margins, for example, in 1999, compared with other hospitals, including major teaching and other teaching hospitals. The inpatient margins for cancer hospitals were negative in 1997 through 1999. These data are presented for other hospitals in your mailing materials.

So based on this evidence that we uncovered about the higher unit cost, the narrower service mix, the lack of ability to offset outpatient margins with inpatient revenues, and the lack of outpatient claims data for the post-PPS data, staff offer the following recommendation for the Commission to consider.

DR. NEWHOUSE: I'm fine with the recommendation. I have one suggestion and one observation. The suggestion is a small one. Could you tell us somewhere in the text -- if you know it now -- what the total dollars Medicare spends on cancer hospitals are? That, I think, would help put this in context.

MS. RAY: I can get that for you.

DR. NEWHOUSE: And the observation is that this table you show us on page 16 that has the margins, it looks to me like there's a problem on the inpatient side as well. The margins go minus three, minus five, minus seven, from '97 to '99. It looks to me like we need to consider what would amount to re-basing the cancer hospitals on the inpatient side as well. Again, this was sort of the dog that was in the report that didn't bark, and the recommendation.

DR. ROWE: I had several comments and questions. I gave Nancy and Dan a little pre-warning about some of my questions so they might be prepared. Some of you who have been on this group for a while are familiar with my point of view with respect to cancer hospitals and I won't bore you with a recitation of that.

But I do find certain aspects of the document to be an apologia for the very well-developed, very well-funded, very effective cancer hospital lobby. I don't accept the view that cancer hospitals systematically treat sicker patients. In fact I believe that the general hospitals that have larger cancer patient populations treat sicker patients because they have patients who have heart disease, diabetes, and other problems, where they have cardiologists, and they have gastroenterologists, and other people on their staff rather than just cancer specialists.

The general hospitals tend to treat older patients with more comorbidities, et cetera. To suggest that state-of-the-art care is available in these 11 hospitals suggests it isn't available in the other hospitals, such as the Cleveland Clinic or the University of Chicago Medical Center, et cetera, where there's just as much, if not more, NIH support, and there are in fact just as many NIH-supported centers, and so on.

So I have a concern about that. I would like the document to be re-read with respect to that general point of view.

With respect to the specific issues here, there are 11 of these cancer hospitals, and they vary dramatically. My understanding is the one in Boston is not even a hospital. It is an outpatient clinic. All the beds are in the Brigham. So it's not a hospital. That's the Dana Farber. Then there are others where there are very large inpatient programs and very small outpatient programs.

So the estimates we see with respect to the proportion of revenues that are outpatient don't share any estimate of variance around those numbers. I would submit that there's a subset of these hospitals that are very much like general hospitals with respect to their inpatient-outpatient mix, and therefore don't necessarily need special treatment respect to their outpatient reimbursement. And there are others that really are very much at risk.

Most people who run large hospitals -- Ralph is not here but I think he would support this if he were -- lose money on the outpatient and make money on the inpatient. That's generally the way it works. And if all you have is outpatient, that's not a good design with respect to that.

So I would propose that we might get more information than we get from that mean number by looking at the variation within this group. There may be two subsets.

Another thing I would say, which really gets to Joe's point about the negative margins, is that the chapter deals with Medicare margins. Sometimes it says Medicare margins and other times it just says inpatient or outpatient margins, but it means Medicare margins. I submit that these hospitals have higher proportions of patients who are private pay, that come from outside the United States, and that their overall margins may in fact not be reflected by their Medicare margins. So that we may not have a complete view on the data with respect to this.

So in summary, my view is that I'm very sympathetic to the need for those institutions which are disproportionately disadvantaged by the nature of their inpatient-outpatient mix to -- we don't want them to be disincented to take care of Medicare beneficiaries because they do provide excellent care. It is state-of-the-art, as is available in other places. So we want to incent them to take care of our beneficiaries.

I think we should do something about those institutions. But I don't think that that necessarily means all of these institutions, and I don't think that the Medicare margins, per se, accurately reflect necessarily the overall performance of the overall institution.

MR. HACKBARTH: Nancy and Dan, did you have some response?

DR. ZABINSKI: Just a few comments. On the variation, there is a fair amount of variation on the outpatient margins. But I would say there's even more variation on the inpatient margins.

DR. NEWHOUSE: I thought Jack meant on the share of the revenue that was outpatient, not the margin.

DR. ROWE: Right.

DR. ZABINSKI: That, offhand, I don't know.

The total margins that you referred to, I ran those numbers like three months ago and I don't recall if I really vetted those, really said that these are okay. I mean, I remember I ran them and I remember the results are actually pretty reflective of the overall Medicare margins we have in the paper. But I can't say I would put a lot of faith in it at this time because I don't recall if I really okayed them or not.

DR. ROWE: They are what they are. But I think that it might be helpful to have them.

MS. RAY: I just want to add one thing, just to follow up on Jack's point. It is correct that overall Medicare accounts for a smaller percentage of their revenues. Again, just looking at the 11 total. It's approximately 17 percent versus overall for all other hospitals, 30 percent.

MR. HACKBARTH: So, Jack, your point of view, in a nutshell, is maybe the category defined is too broad and includes actually quite dissimilar institutions. And for some subset the arguments raised may be valid, but we shouldn't just buy it because it's labeled a cancer hospital.

DR. ROWE: Right. I would say two things. One is I'm very interested in making sure there's no disincentive with respect to our beneficiaries in Medicare having access to the services of these institutions. These are wonderful institutions. I just don't like the idea that they're the only wonderful cancer treatment options in the United States, which is sometimes what you hear. So that's number one.

Number two is, I would suggest that maybe what we do is say, for those institutions in this category that have a substantially higher -- pick a number, whatever, I don't care -- proportion of their Medicare revenues that are outpatient, that they should be eligible for this special treatment. But in fact they don't, then I think the argument falls apart, and then I wouldn't give it to those.

DR. NEWHOUSE: The problem I see with that, Jack, is that could well be true, and probably is true, for other hospitals.

DR. ROWE: I understand that. That's why I don't think should be a special group at all. But here we are. It's a special group.

DR. NEWHOUSE: But then the next group we'll hear from will be the short term general hospitals that have a high outpatient revenue.

MR. HACKBARTH: We did hear from one subgroup of those, the rural hospitals, who had, in some way, similar conditions where a disproportionate share of their revenues came. And we in fact reached the recommendation that gives those conditions we ought to be very careful about the application of outpatient PPS. So I don't think we would be breaking new ground to say, for hospitals

that have these conditions, we need to be careful, as opposed to hospitals that bear the label cancer hospital as applied by NIH.

DR. REISCHAUER: But there is a difference and that was there weren't alternatives with respect to the rural ones. What Jack is saying is, they're wonderful, but there are other wonderful places a few blocks away.

MR. HACKBARTH: Actually, that's a good question. I don't remember off the top of my head that that was key to our rationale in talking about rural hospitals. I think it was more that they were unusually dependent, and therefore, at risk. It wasn't because they were sole community facilities. We didn't say, only sole community rural hospitals we ought to be careful about outpatient PPS. We said across the board.

DR. REISCHAUER: No, but that's because with the word rural comes an understanding --

DR. NEWHOUSE: Also, is it clear that in fact things are fine on the inpatient side? Obviously these institutions are existing so they're making it somehow. But our general philosophy -- I don't recall immediately the rural margins on the inpatient side, but it seemed to me -- the Medicare margins, they looked better than what we're seeing here.

DR. WAKEFIELD: They were negative also.

DR. NEWHOUSE: But not as negative as this. I'm not even sure they were negative.

DR. WAKEFIELD: I can't remember, but both were negative. Their overall margins were higher, their inpatient and outpatient, and Medicare overall were lower.

MR. HACKBARTH: Jack's comment resonates for me personally because, for example, when we did the testimony on the rural report, one of the themes was that we want to target relief. We want to adjust payment systems so that they appropriately reflect efficient cost. We want to depart from these big labels and say, let's just give more money to all rurals. We systematically rejected those options for more targeted ones.

It seems to me what Jack is saying, that same way of thinking applies here. We've got a big label that in fact covers disparate institutions. Let's couch our recommendation in terms of particular conditions. If a given cancer hospital has them, fine. But if they don't, we ought not give them the relief. To me that's one of the cardinal principles of MedPAC policy and world view.

DR. ROWE: I think that reflects what I'm saying. I certainly don't want to be interpreted by anyone as saying, because I've got this thing about this category, that I don't want to help these elements in this category that need help. They do it. They're great places. The last thing I want to do is have anything to do that leads to Medicare beneficiaries not getting access to good care. I just think we need to be a little more targeted.

MS. BURKE: If there are only 11 of them, and Dana Farber, which is a strange circumstance, how big is the variance among them?

DR. ZABINSKI: In terms of what?

MS. BURKE: Inpatient versus outpatient. I mean, the

variance among rural hospitals is considerable in large part because there are a considerable number of rural hospitals who have very different circumstances. How varied are, in fact, these hospitals for which this special exclusion applies?

DR. ZABINSKI: Not certain.

MS. BURKE: Do we have any idea.

DR. ZABINSKI: Not right now.

MS. RAY: We can find that out.

DR. ZABINSKI: That's real easy to come up with.

MS. BURKE: I think Jack raises a very good point. We ought to have some sense of how widely variable they are. My guess is there may be a couple of outliers but they may otherwise be consistent. Whether M.D. Anderson and Sloan -- I mean, I don't know the answer to that question. But there's certainly a much smaller universe so you've got to assume there has to be --

DR. ROWE: If we could at least just see that table. Maybe I'm wrong, in which case, fine. That's fine, too.

MR. HACKBARTH: It seems to me that's the immediate next step. Jack has framed some questions that require digging a little bit deeper on the data. Let's take a look at that. Murray appropriately points out, the way the recommendation is couched is, until we have better data. We may conclude after the next meeting that there are still more questions that we want to ask. The thrust of this is, let's err on the side of not making a big mistake until we can target adjustments or relief appropriately. That's certainly something that I can endorse.

Nancy and Dan, any questions about what we're asking you to do?

DR. ROSS: I guess one question is, Dan, how quickly could you come back to us with something? Is this a set of facts you can bring back tomorrow?

DR. ZABINSKI: Yes.

DR. WAKEFIELD: Have a good evening, Dan.

[Laughter.]

DR. ROSS: In return for one Thursday evening, he might get a whole month, is what I'm trying to --

DR. ZABINSKI: No, it wouldn't be a big deal.

DR. ROWE: So is it clear what we want?

DR. ZABINSKI: I get the idea that you want a table that shows the variation, the proportion of revenue that comes from outpatient. You want to look at total margins.

DR. ROWE: You could even, if you have it, because you have to have it in order to get -- just list them, A through K, and then what the mean is. Then it will be obvious.

DR. ZABINSKI: I've got basically two tables.

DR. ROWE: Don't put their names. Just put A to K.

MS. RAY: We can do that.

MR. HACKBARTH: That would be very helpful, Dan, and we'll figure out where we can put it in tomorrow's --

DR. ZABINSKI: I can be back here in an hour if you want me to.

MR. HACKBARTH: Come back tomorrow. Any other questions about direction? Jack is up next, right? Assessing payment adequacy.